

TennCare Patient Centered Medical Home: Provider Operating Manual 2018

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This operating manual outlines the PCMH program guidelines and policies effective January 1, 2018. The guidelines for 2017 are still valid for all claims with dates of service in 2017.

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All information included herein is subject to further updates and refinement from TennCare.

1 GENERAL INFORMATION

1.1 Objective of Patient Centered Medical Homes (PCMH) in Tennessee

PCMH is a comprehensive care delivery model designed to improve the quality of primary care services for TennCare members, the capabilities of and practice standards of primary care providers, and the overall value of health care delivered to the TennCare population.

Tennessee has built on the existing PCMH efforts by providers and payers in the State to create a robust PCMH program that features alignment across payers on critical elements. A PCMH Technical Advisory Group (TAG) of Tennessee clinicians was convened in 2015 to develop recommendations in several areas of program design including, quality measures, sources of value, and provider activity requirements.

1.2 Sources of Value

PCMH is a comprehensive care delivery model designed to improve the quality of primary care services for TennCare members, the capabilities and practice standards of primary care providers, and the overall value of health care delivered to the TennCare population.

Successfully executed, the PCMH program will deliver a number of benefits to members, providers, and the system as a whole. A few of the most important benefits are outlined in Table 1.

TABLE 1 – Sources of Value

Members	Practices	System
<ul style="list-style-type: none">▪ Better access to primary care providers▪ Tailored care for those most in need▪ Care coordination services leading to improved quality and outcomes▪ Greater emphasis on primary and preventative care▪ Improved care coordination with behavioral health providers	<ul style="list-style-type: none">▪ Support for performance improvement▪ Direct financial support for care coordination▪ Specialized training for practice transformation▪ Access to outcome payments▪ Input from other members of care delivery team▪ Access to better information with which to make decisions▪ Improved work flows and processes that positively impact productivity and efficiency	<ul style="list-style-type: none">▪ Higher quality care▪ Reduced total cost of care<ul style="list-style-type: none">– Reduced utilization of secondary care through better management of chronic conditions– Reduced utilization of unnecessary procedures and visits (e.g., unnecessary emergency room visits)– More cost conscious referrals▪ System shift towards greater coordination and information sharing

2 PROVIDER ELIGIBILITY

2.1 Eligibility

TennCare PCMHs will be defined and measured at the Tax ID level. All primary care providers serving Medicaid members under that Tax ID will be included in the PCMH. One PCMH may have multiple physical locations or sites.

All rules, processes, and requirements detailed herein apply only to the TennCare PCMH program. To be eligible for the program:

- 1) The entity must be a participating TennCare practice with one or more PCPs (including nurse practitioners) with any of the specialty types designated by TennCare as primary care practitioners including family medicine, internal medicine, and pediatrics;
- 2) The organization must have at least 500 attributed TennCare beneficiaries contracted under one managed care organization (MCO) at the time of enrollment. The organization may have fewer beneficiaries with other MCOs, however, there must be at least 500 with one MCO;
- 3) The organization attests to commit to the goals of value-based payment including, but not limited to:
 - Increased care coordination
 - Proactive management of the patient panel
 - Focus on improving quality and performance outcomes identified in quarterly reports
 - Integrated care across multidisciplinary provider teams;
- 4) The organization must designate a PCMH Director to serve as point of contact for the State, MCOs, and other parties;
- 5) The organization must commit to the following PCMH activities:
 - Participate in two 2 years of practice transformation and support through the State's provider training vendor (described in Section 9)
 - Maintain Level 2 or 3 PCMH recognition from the National Committee for Quality Assurance (NCQA) **OR** NCQA's 2017 PCMH recognition
 - Sign up and use State's Care Coordination Tool; and
 - Share best practices with other participating PCMH organizations and support other organizations in their practice transformation by participating in learning collaboratives on an ongoing basis

A participating organization remains enrolled in the PCMH program until any of the following occurs:

- 1) The organization withdraws;
- 2) The organization or provider becomes ineligible, is suspended or removed from the TennCare program or the PCMH program; or
- 3) Division of TennCare terminates the PCMH program.

To withdraw from PCMH, the participating organization must email intent to withdraw to payment.reform@tn.gov and to their contracted MCO(s).

2.2 Provider contracting

If selected to participate in TennCare PCMH, an organization must update its contract(s) with the relevant health plan(s). MCO contracting must be completed prior to the start of the performance period on the first of January each year. Organizations will not be required to contract with health plans with which they do not have an existing contract.

If an organization has less than 500 members attributed to a given MCO, that MCO will determine if it will extend a PCMH contract to the organization.

An organization may not participate in two overlapping value-based payment programs with the same health plan simultaneously. The State and health plan will work together to determine if an organization's existing value based payment arrangement with an MCO is duplicative of the TennCare PCMH program. Organizations may need to terminate existing value based payment arrangements in order to participate in the TennCare PCMH to avoid duplication.

3 WHICH MEMBERS ARE IN A PCMH?

3.1 Member Inclusion

The intent of the PCMH program is to be as broad and inclusive as possible. As a result, all TennCare members enrolled with the MCO are eligible for the PCMH program, including adults and children. CoverKids members are not included at this time.

The program explicitly includes individuals that are dually eligible in Medicare and Medicaid if their D-SNP health plans are with the same MCO. Members may be enrolled in both a PCMH and a Tennessee Health Link (THL) organization simultaneously. THL is a program designed to coordinate health care services for TennCare members with the highest behavioral health needs.

All TennCare eligible members attributed to a PCMH are included in the calculation for the monthly activity per member per month payment. Some members are excluded in the calculation for performance evaluation and are therefore excluded from the outcome payment calculation.

Members **are excluded** from the PCMH program performance evaluation under any of the following scenarios (i.e., these members are not counted in quality and efficiency metrics):

Member is dual-eligible but is not enrolled in an aligned D-SNP. Members could be excluded from performance evaluation if they are dual eligible and not enrolled in an aligned D-SNP health plan (at the MCO's discretion). Being "aligned" means that the member is enrolled in a Medicare Advantage D-SNP plan with the same MCO participating in the TennCare Medicaid program. Examples of not being enrolled in an aligned D-SNP health plan include cases where the member is dual-eligible but enrolled in a Medicare Advantage health plan that is not a D-SNP, a D-SNP health plan with another insurer, or Medicare fee-for-service.

Member has or obtains third-party liability (TPL) coverage. Members with confirmed TPL coverage or with a claim within the previous quarter indicating TPL coverage could be excluded from the PCMH program performance evaluation.

Member has a long-term nursing home stay: Members with an active nursing home stay that covers ninety (90) or more consecutive days are not included in the PCMH program evaluation. Members must be discharged to home from a previous nursing home stay to regain PCMH program performance evaluation eligibility.

Member with long-term residential treatment facility stay: Members with one or more residential treatment facility (RTF) claims that cover more than ninety (90) consecutive days that are ongoing as of the eligibility update start date are not included in the PCMH program evaluation. Members must be discharged to home from a previous RTF stay to regain PCMH program performance evaluation eligibility.

Member has less than nine (9) months of attribution to that PCMH: Only those members with at least nine (9) months of cumulative attribution to the PCMH are counted towards performance outcomes. These nine (9) months do not have to be consecutive. This policy is in place to ensure that the provider has had adequate time with the member to affect their quality and efficiency outcomes.

Once excluded, a member may become eligible again for the PCMH program if his or her exclusion status changes.

3.2 Member Attribution

Attribution uses the existing member to PCP assignment conducted by the MCOs today. Members are attributed each month to the PCMH associated with the member's active PCP. If the member's PCP is not part of an organization that participates in the PCMH program, the member will not be attributed to any PCMH for the month. If a provider wishes to remove a member from their attributed panel, this program will follow the same guidelines/existing rules that each MCO already has in place for member change requests submitted by primary care providers.

4 WHAT SERVICES WILL A PCMH PROVIDE?

The PCMH organizations will provide team-based care, patient-centered access, care coordination, and improved quality of care to their members. To ensure that these principles are being achieved, each PCMH will be required to maintain or achieve NCQA recognition (refer to Section 5.2 for further detail).

The following are functions each PCMH will do to ensure patients receive enhanced patient-centered care:

1. **Team-based care and practice organization:** The PCMH provides continuity of care; communicates roles and responsibilities of the medical home to patients/families/caregivers; and organizes and trains staff to work to the top of their license and ability to provide effective team-based care.
2. **Knowing and managing your patients:** The PCMH captures and analyzes information about the patients and community it serves, and uses the information to deliver evidence-based care that supports population needs and provision of culturally and linguistically appropriate services.
3. **Patient-centered access and continuity:** Patients/families/caregivers have 24/7 access to clinical advice and appropriate care facilitated by their designated clinician/care team and supported by access to their medical record. The PCMH considers the needs and preferences of the patient population when establishing and updating standards for access.
4. **Care management and support:** The PCMH identifies patient needs at the individual and population levels to effectively plan, manage, and coordinate patient care in partnership with patients/families/caregivers. Emphasis is placed on supporting patients at highest risk.
5. **Care coordination and transitions:** The PCMH tracks tests, referrals, and care transitions to ensure comprehensive care coordination and communication with specialists and other providers in the medical neighborhood.
6. **Performance measurement and quality improvement:** The PCMH collects reports and uses performance data to identify opportunities for quality improvement; sets goals and acts to improve clinical quality, efficiency, and patient experience; and engages the staff and patients/families/caregivers in the quality improvement activities.

5 HOW WILL A PCMH BE PAID?

5.1 Fee-for-service

The current fee-for-service delivery model will remain unchanged under the PCMH program.

5.2 Practice Support Payments

Practice support payments are per-member-per month (PMPM) payments made to the PCMH to support the delivery of care under the PCMH model.

There are two (2) components to practice support payments:

1. Practice transformation payments; and
2. Activity payments

Both types of practice support payments are calculated retrospectively. The payments are calculated and made on a monthly basis.

The **practice transformation payment** is set at \$1 PMPM and is provided for the first year of program participation only. This value is not risk adjusted.

The **activity payment** is a risk adjusted PMPM amount and will continue throughout the duration of the program. Each PCMH will receive their PMPM payment amount from the MCO based on the risk of their membership panel. The payments will primarily support the PCMH for the labor and time required to improve and support their care delivery models. PCMHs may hire new staff (e.g., care coordinators) or change responsibilities for existing staff to support the required care delivery changes.

Determination of risk-adjusted activity payment amounts

Activity payment amounts are risk-adjusted to account for differences in the degree of care coordination required for members with serious or chronic health conditions. Refer to Section 8 for further detail of the risk adjustment methodology.

While the payment amount per risk band is left to MCO discretion, the average payout across all of an MCO's PCMHs must average at least \$4 PMPM. No PMPM will be less than \$1.

At the beginning of each performance period, a practice risk score will be calculated that will define the PCMH's risk for the year. The MCO will determine the PMPM amount based on that risk. The PCMH risk score will be updated annually before the

start of the next performance period to account for changes in the PCMH risk over time.

Requirements for Activity Payment

- 1) Initial eligibility: requirements for payments will be contingent on enrollment in the PCMH program as defined in Section 2.2.
- 2) Activity requirements: Practices must perform all activities in order to continue receiving payments. The organization must commit to the following PCMH activities:
 - Maintain Level 2 or 3 PCMH recognition from the National Committee for Quality Assurance (NCQA) **OR** NCQA's 2017 PCMH recognition (Refer to NCQA Requirement- Detail below);
 - Sign up and use State's Care Coordination Tool (Refer to Section 11 for further detail on the CCT); and
 - Share best practices with other participating PCMH organizations and support other organizations in their organization transformation by participating in learning collaboratives on an ongoing basis

NCQA Requirement - Detail:

Organizations with NCQA Level 2 or 3 recognition automatically meet the minimum requirements for TennCare's PCMH until their recognition expires. When that recognition expires, these organizations must transition to NCQA's 2017 standards to maintain eligibility for the TennCare's PCMH program.

Organizations should obtain NCQA 2017 recognition for all of their sites by the deadline set by the State or at the time of their current recognition's expiration. For example, organizations that begin program participation on January 1, 2018, and have sites that do not have NCQA recognition, will be expected to enroll in Q-Pass by May 31, 2018. They will be expected to submit payment through the State's discount by June 30, 2018. Recognition is expected to be achieved by June 30, 2019 (12 months later).

Organizations with a current NCQA PCMH 2011, PCMH 2014 or PCMH 2017 recognition for their sites are expected to renew each site's recognition using the NCQA PCMH 2017 program Standards and Guidelines, on or before their current recognition expiration. For example, an organization with a PCMH 2014 Level 2 recognition that expires on October 30, 2018 must renew that recognition no later than October 30, 2018. Thus, it is recommended that an organization would need to start the renewal process at least six months prior to the October 30, 2018 expiration date, which is April 30, 2018.

It's important to note that NCQA recognition is evaluated at the site-level. Multi-site organizations with different recognition statuses for each site must obtain recognition for those sites whose recognition is set to expire and/or do not have current recognition.

Below is an example of a multi-site organization with 3 sites that have different recognition statuses. This organization would be expected to do the following:

- Site one has PCMH 2014 recognition that expires May 22, 2020 and is in compliance with program requirements.
- Site two has never obtained NCQA recognition and will be expected to obtain NCQA 2017 recognition by the deadline set by the State.
- Site three has PCMH 2011 recognition set to expire June 3, 2018 and will be expected to renew recognition using the NCQA PCMH 2017 program Standards and Guidelines, no later than June 3, 2018.

TennCare will fund fees associated with the NCQA 2017 PCMH process and provide organizations with guidance on achieving recognition. If an extension is necessary, an organization must submit a request for extension to TennCare no later than two (2) months before the deadline. The extension request will require a justified explanation from the practice and Navigant coach for the delayed recognition.

NCQA's 2017 standards are available here:

<http://www.ncqa.org/Portals/0/Programs/Recognition/PCMH/2017%20PCMH%20Concepts%20Overview.pdf?ver=2017-03-08-220342-4902017>

Addition of organization transformation payment amounts

The organization transformation payment amount (\$1 PMPM) paid in the first year of participation is added to the adjusted activity payment amount to determine the total organization support payment PMPM for the member.

On the whole, organization support payment amounts are summed across members attributed to a PCMH to obtain the total organization support payment amount for the PCMH organization for each month.

5.3 Outcome Payments

Outcome payments are designed to reward the high performing PCMHs for providing high-quality care while effectively managing overall spending. There are two (2) kinds of outcome payments:

Outcome payments based on total cost of care (TCOC): For high volume panel PCMH organizations with 5,000 or more members, savings on TCOC generated through the PCMH program will be shared based on each PCMH organization's actual risk-adjusted TCOC relative to its benchmark TCOC; and

Outcome payments based on efficiency metric improvement: For low volume panel practices with fewer than 5,000 members, PCMH organizations may earn outcome payments for annual improvement on efficiency metrics compared to the performance on the same metrics in the previous year.

PCMH organizations are eligible for either type of outcome payment **only** if the PCMH earns a minimum number of quality stars: two (2) for pediatric and adult PCMHs, four (4) for family PCMHs.

Outcome Payments for High Volume PCMHs

Outcome payments are based on total cost of care for high volume PCMHs. For large-panel PCMH practices (or pooled shared savings entities) with 5,000 or more members, savings on TCOC generated through the PCMH program will be shared based on each PCMH practice's actual risk-adjusted TCOC relative to its benchmark TCOC.

For high volume PCMH organizations who qualify for an outcome payment by meeting minimum requirements outlined in previous sections, the outcome payment amount is calculated as follows:

Risk-Adjusted TCOC Savings Amount	×	Maximum Share of Savings	×	Outcome Savings Percentage	×	Member Months	=	Outcome Payment
Saving		50%		0 to 100%		# Attributed		

The risk-adjusted TCOC savings are calculated by taking the difference between the actual risk-adjusted TCOC and the benchmark TCOC for each PCMH in a given performance year. If the PCMH organization's actual costs are higher than their benchmark, then TCOC savings amount is zero and no outcome payment is earned that year. If the result is a positive amount, then those savings are considered an improvement in TCOC performance.

- Maximum share of savings

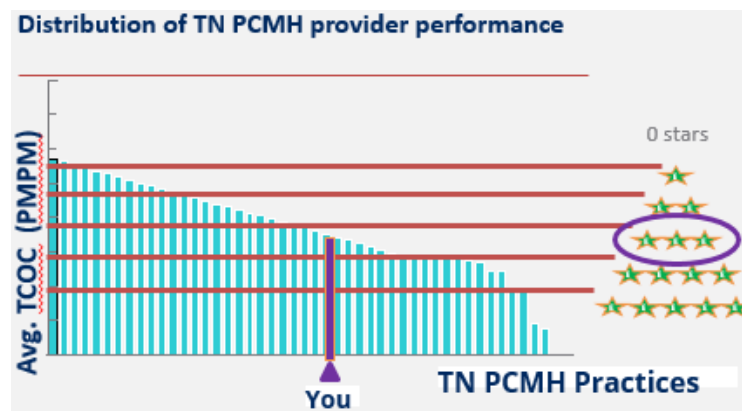
The maximum percentage of estimated savings that can be shared with a PCMH. This value is set to 50% for outcome payments based on total cost of care.

- Outcome savings percentage

Of the possible maximum shared savings, each high volume PCMH receives a percentage based on its performance. This percentage is known as the outcome savings percentage and is based on the number of stars earned by each practice.

PCMHs and pools with greater than 5,000 attributed members are evaluated on total cost of care improvement. This evaluation results in the awarding of “efficiency stars.” These stars are awarded based on the PCMH’s actual risk adjusted TCOC as compared to state level thresholds, and is meant to reward PCMHs that already perform very efficiently relative to their peers. The methodology to set thresholds for awarding efficiency stars is part of the State threshold documentation.

Each high volume PCMH is awarded efficiency stars based on its risk-adjusted TCOC. Risk-adjusted TCOC thresholds for the number of efficiency stars to be awarded will be provided in a separate document. A sample of a practice earning three (3) efficiency stars is below.



Then, quality stars and efficiency stars are combined to calculate the outcomes savings percentage. Each efficiency star earned by the PCMH organization contributes 10% to the outcome savings percentage. Each quality star earned by the PCMH organization contributes 10% to the outcome savings percentage for adult and pediatric PCMH organizations and 5% for family PCMH organizations.

For example, the following pediatric PCMH organization would have an outcome savings percentage of 70%:

Pediatric practice		
Quality stars earned	★★★★☆	(4 stars) X 10% = 40%
Efficiency TCOC stars earned	★★★★☆	(3 stars) X 10% = 30%
		Outcome savings percentage = 70%

- Member months

Risk- adjusted TCOC savings amounts are on a per member basis until this point. In order to convert to total shared savings for the PCMH practice, the savings are multiplied by the total number of attributed member months with the MCO. Only member months for members in each PCMH's annual performance panel are included in this calculation. See Section 3.1.

Outcome Payments for Low Volume PCMHs

For low-volume practices with fewer than 5,000 members, practices may earn outcome payments for annual improvement on efficiency metrics compared to the performance on the same metrics in the previous year. Low volume PCMH practices are eligible for outcome payments only if PCMH practices earned a minimum number of quality stars: two (2) for pediatric and adult practices, four (4) for family practices.

For low volume PCMH organizations who qualify for an outcome payment by meeting minimum requirements outlined in previous sections, the outcome payment amount is calculated as follows:



The following subsections detail each component of this formula.

- Average total cost of care (TCOC) per member per month (pmpm)

This is the average total cost of care per member per month for members in PCMH across all of TennCare. The statewide average TCOC amount to be used is \$234.

- Efficiency performance

Efficiency performance is calculated by adding the percentages earned from both efficiency improvement and efficiency stars. The maximum total efficiency performance percentage is 50.00%.

a. Efficiency Improvement Percentage

The efficiency improvement percentage will reward PCMH organizations which have improved relative to their previous year's performance. The efficiency improvement percentage is the average of improvement in each efficiency metric compared to previous year's performance for the PCMH. Efficiency improvement for a given metric is calculated as the following:

$$\left(\begin{array}{c} \text{Efficiency} \\ \text{Improvement} \\ \text{Percentage} \end{array} \right) = \frac{\left(\begin{array}{c} \text{Efficiency metric 1} \\ \text{Prior year value} \end{array} \right) - \left(\begin{array}{c} \text{Efficiency Metric 1} \\ \text{Current value} \end{array} \right)}{\left(\begin{array}{c} \text{Efficiency metric 1} \\ \text{Prior year value} \end{array} \right)}$$

If the efficiency metric value for the previous year could not be calculated, then the efficiency improvement for that given metric is considered to be zero. After calculating the efficiency improvement percentage for each efficiency metric, the average of the two (2) is taken.

TABLE 6: Illustrative Example of Efficiency Improvement Percentage

Note: Values rounded to nearest hundredth decimal place

Efficiency Measure per 1,000 Member Months	Performance at Baseline (CY2017)	Performance Since 1/1/18	Efficiency Improvement
ED Visits	78.10	76.00	2.69%
Inpatient Discharges	3.00	2.80	6.67%
EFFICIENCY IMPROVEMENT PERCENTAGE (AVERAGE)			4.68%

If the average of the efficiency improvement percentage results in a negative number, it will be set to 0 and if the average calculation exceeds 20% it will be capped at that value. In addition, each individual measure's efficiency improvement is capped at positive and negative 20.00%. In other words, if your organization sees a decrease in efficiency of 31.25%, it will only show a decrease of 20.00%.

b. Efficiency Stars

Performance must meet or exceed the benchmark in order to earn an efficiency star. Each efficiency star earned contributes 15.00% to the efficiency performance. These benchmarks are set by each MCO and will be different for pediatric PCMHs and family practice PCMHs.

- Maximum share of savings

The maximum percentage of estimated savings that can be shared with a PCMH. Low volume PCMH organizations may earn up to 25% of the total savings achieved during a year.

- Quality performance

Performance must meet or exceed the benchmark in order to earn a quality star. Each quality star earned by the PCMH organization contributes to the quality performance. Beginning with the 2018 performance year, the redistribution of quality values may be applied under certain circumstances.

Most of the quality metrics are defined by HEDIS. HEDIS requires that an organization have at least thirty (30) observations in the denominator of any metric for it to be measured accurately. If an organization does not have at least thirty (30) observations during a calendar year for a given HEDIS metric, that organization is ineligible for that particular quality star. The potential value of each ineligible quality star will be redistributed. See Section 7.5 for details.

- Member months

Number of member months enrolled with the MCO for all members in the PCMH's outcome panel, as defined in Section 3.1.

6 PCMH REMEDIATION PROCESS

The remediation process is initiated when a PCMH organization fails to meet deadlines and/or performance targets on required program activities. A PCMH may trigger probation, remediation, and/or removal under any of the following circumstances, at the discretion of each MCO:

- Not meeting program requirements (e.g. NCQA recognition requirements)
- Poor performance defined as:
 - A family PCMH earning 2 or fewer quality stars at the end of a performance period (12 months); or
 - A pediatric or adult PCMH earning 1 or fewer quality stars at the end of a performance period (12 months); or
 - PCMH earning 1 or fewer efficiency stars at the end of a performance period (12 months)
- Failure to respond and meet with MCO and/or TennCare

The remediation process includes three (3) phases outlined below.

Probation- Phase One

- A PCMH organization is placed on probation by TennCare and the MCO(s) for not meeting performance and program requirements. A letter is issued by TennCare to a PCMH organization outlining the reasons for the probation and the six-month period for review. TennCare and MCO(s) will be in monthly contact with clear communication regarding a PCMH organization's probation status. TennCare will provide a copy of the letter to the MCO(s).
- If after the six (6)-month period, a PCMH organization has not been able to correct their performance and program issues, MCO(s) will notify TennCare by letter. Prior discussions, documentation, and reports will also be provided to TennCare.
- After receiving the letter and other PCMH organization documentation from the MCO(s), TennCare will issue a final probation letter, outlining the performance and program requirement issues, to a PCMH organization within three (3) calendar days. TennCare will provide a copy of the final probation letter to the MCO(s).
- After receiving the final probation letter, a PCMH organization will be required to work with the MCO(s) and those providing coaching to write a corrective action plan. The corrective action plan must be submitted to the MCO(s), TennCare, and coach(s) within thirty (30) calendar days of receiving the final probation letter for review and approval.

- A PCMH organization will remain in probation status for the duration of the period outlined in the corrective action plan, in which a PCMH organization will be reevaluated based on their corrective action plan and performance improvement. If performance has not improved, then the MCO(s) will notify TennCare and the PCMH organization will be moved into the remediation phase.

Remediation- Phase Two

- After receiving notification by the MCO(s) that a PCMH organization's corrective action plan has not been followed or performance improvement has not occurred within the specified time period, TennCare will notify a PCMH organization that they are in remediation within three (3) calendar days by letter.
- MCO(s) will review the corrective action plan and work with coaches a second time to determine if a PCMH organization is making improvements in performance and/or program requirement issues by doing further analysis.
- MCO(s) will stop activity payments if corrective action plan is not followed or performance and/or program requirement issues are not met.
- MCO(s) may move a PCMH organization from remediation to probation under a revised corrective action plan at their discretion.

Removal from PCMH- Phase Three

- TennCare and MCO(s) will work together within ten (10) calendar days to determine if a PCMH organization has not fulfilled their corrective action plan and if they should be removed from the program.
- TennCare will notify MCO(s) within three (3) calendar days of their decision to remove a PCMH organization.

MCOs will terminate all of a PCMH organization's provider payment streams after receiving a removal letter from TennCare.

- TennCare and MCO(s) reserve the right to remove a PCMH organization from the program in less than ten (10) calendar days in extreme circumstances.

7 HOW WILL QUALITY AND EFFICIENCY BE MEASURED?

7.1 Quality Measures

Quality metrics are tracked to ensure that PCMHs are meeting specified quality performance levels and to provide them with information they can use to improve the quality of care they provide.

There are three (3) types of PCMH organizations for purposes of determining performance: pediatric, adult, and family practices. For the purpose of organization type setting, members aged 21 or younger are considered to be children, and all other members are considered to be adults. PCMH organization type is determined based on the percentage of adults and children on an organization's panel as well as the number of adults and children on the organization's panel.

Practice type is defined in two (2) steps.

1. Determine the percentage of adults and children in an organization's panel.
 - a. If the organization's attribution from that MCO is 70% or more children, the organization may be a pediatric practice
 - b. If the organization's attribution from that MCO is 70% or greater adults, the practice may be an adult practice.
 - c. If the organization's attribution from that MCO has a mixture of adults and children that does not meet one of the above criteria, it is a family organization.
2. If a member panel has more than 500 children members and also more than 500 adult members attributed, it is a family organization. This step overrides the first step of determining percentages.

The organization type of each PCMH is determined at the beginning of each year, and an organization's type remains constant for the duration of the performance period.

Various quality performance metrics are used across the three (3) types of organizations. Adult and pediatric organizations will be evaluated on five (5) quality metrics, while family organizations will be evaluated on ten (10) quality metrics, as shown in Table 3.

Core quality metrics that will be used to determine outcome payment levels are shown in Table 3. Some measures are grouped into composites. Each composite is worth one quality star. All eligible sub-measures within a composite must meet or exceed the threshold in order for a practice to earn that star. Additional reporting only metrics will also be provided on reports. There is a more detailed table with sources and descriptions in Section 12 – Quality Appendix – Tables 7 and 8.

TABLE 3– Quality Metrics by PCMH Organization Type

Pediatric Practice Quality Metrics

- ① **EPSDT screening rate (composite for older kids)**
Well-child visits ages 7-11 years
Adolescent well-care visits age 12-21
- ② **Asthma medication management**
- ③ **Immunization composite metric**
Childhood immunizations
Immunizations for adolescents
- ④ **EPSDT screening rate (composite for younger kids)**
Well-child visits first 15 months
Well-child visits at 18, 24, & 30 months
Well-child visits ages 3-6 years
- ⑤ **Weight assessment and nutritional counseling**
BMI percentile
Counseling for nutrition

Adult Practice Quality Metrics

- ① **Adult BMI screening**
- ② **Antidepressant medication management**
- ③ **EPSDT: Adolescent well-care visits age 12-21**
- ④ **Comprehensive diabetes care (composite 1)**
Diabetes care: eye exam
Diabetes care: BP < 140/90
Diabetes care: nephropathy
- ⑤ **Comprehensive diabetes care (composite 2)**
Diabetes HbA1c testing
Diabetes HbA1c poor control (>9%)

Family Practice Quality Metrics

- ① **Adult BMI screening**
- ② **Antidepressant medication management**
- ③ **Comprehensive diabetes care (composite 1)**
Diabetes eye exam
Diabetes BP < 140/90
Diabetes nephropathy
- ④ **Comprehensive diabetes care (composite 2)**
Diabetes HbA1c testing
Diabetes HbA1c poor control (> 9%)
- ⑤ **Asthma medication management**
- ⑥ **Immunization composite metric**
Childhood immunizations
Immunizations for adolescents
- ⑦ **EPSDT screening rate (Composite for youngest kids)**
Well-child visits first 15 months
Well-child visits at 18, 24, & 30 months
- ⑧ **EPSDT: Well-child visits ages 3-6 years**
- ⑨ **EPSDT Screening (Composite for older kids)**
Well-child visits ages 7-11 years
Adolescent well-care visits age 12-21
- ⑩ **Weight assessment and nutritional counseling**
BMI percentile
Counseling for nutrition

7.2 Efficiency Measures

Efficiency metrics are tracked to ensure that low- volume PCMHs are meeting specified efficiency performance levels and to provide them with information they can use to improve the quality of care they provide. Core efficiency metrics that will be used to determine outcome payment levels are shown in Table 4. Additional reporting only metrics will also be provided on reports. There is a more detailed table with sources and descriptions in Section 12 – Quality Appendix- Table 7.

TABLE 4 – PCMH Efficiency Metrics

PCMH Efficiency Metrics per 1,000 member months	
1	Ambulatory care - ED visits
2	Inpatient discharges - Total inpatient

7.3 Total Cost of Care Calculation

Total cost of care (TCOC) refers to average total spending of the members in a PCMH's panel, adjusted for the member months during which the member was eligible for TennCare. At the end of each quarter, the TCOC is generated for the PCMH report, based on each PCMH's member panel for performance. The following calculations are displayed in each PCMH report:

- Non-risk-adjusted TCOC
- Risk-adjusted TCOC
- Non-risk-adjusted TCOC for behavioral health

TCOC amounts are used to calculate outcome payments for practices with 5,000 or more members. In order to support the calculation of outcome payments based on total cost of care, a baseline and benchmark TCOC is calculated for each PCMH, in addition to the actual TCOC. Baseline and benchmark TCOCs are calculated on risk-adjusted basis only.

For PCMH organizations with less than 5,000 members, TCOC amounts will be displayed for informational purposes only. Each of these TCOC calculations is discussed in greater detail in the sections that follow.

▪ **Definition of Total Cost of Care**

The total cost of care is meant to capture the total cost of an average member in a PCMH's organization. Using this, the MCOs can calculate the savings a practice has generated and share in those savings with organizations.

For purposes of the PCMH program, there are six (6) categories of spending excluded from TCOC calculation:

- Dental
- Transportation
- NICU and nursery
- Any spending during the first month of life
- Mobile Crisis Capitation payments
- Medication therapy management (MTM) payments for CY2018

In addition to traditional claims-based payments, there are three (3) types of spending incorporated into the TCOC calculation:

- PCMH activity payments are considered a cost associated with delivering care. As a result, the activity payments from the prior quarter are added to TCOC at the member level;
- Tennessee Health Link support payments are also considered a cost associated with delivering care. Tennessee Health Link payments from the previous quarter are added to TCOC at the member level; and
- Gain-sharing payment made to the PCMH as a Principal Accountable Provider (i.e. Quarterback) of episode-based payment models.

▪ **Actual Total Cost of Care**

Actual total cost of care for a PCMH is calculated as a per-member-per-month metric, on a separate basis for each MCO with which the PCMH contracts.

Non-risk-adjusted TCOC is defined as the sum of spend included in TCOC divided by the sum of the number of enrollment months with the MCO, for all the members in the PCMH's panel. In other words, across all members of the PCMH's panel within an MCO:

$$\text{Non risk adjusted TCOC} = \frac{\sum \text{Included Spend}}{\sum \text{Member months with MCO}}$$

Risk-adjusted TCOC reflects the risk score of the members in the PCMH's panel, and includes a maximum spend cap to remove the impact of outliers. Risk-adjusted TCOC for a PCMH organization is calculated by summing the included spend for all members in the PCMH's outcome payments panel, capped at a set amount per member (to be provided with State thresholds), and dividing by the sum of each member's risk score multiplied by the number of months each member was enrolled with the MCO during the year. In other words, across all members of the PCMH's panel within an MCO:

$$\text{Risk adjusted TCOC} = \frac{\sum \text{Capped spend}}{\sum (\text{Member months with MCO} * \text{Adjusted risk score})}$$

Non-risk-adjusted TCOC for behavioral health is defined analogously with the non-risk-adjusted TCOC above, but taking into account only the BH spend. For non-risk-adjusted TCOC for behavioral health, spend included is spend that meets the BH spend definition as well as the TCOC definition.

▪ **Baseline Total Cost of Care**

The baseline TCOC for each PCMH is the 3-year average of risk-adjusted TCOC for the given PCMH, and is used to estimate the historical per member cost of care for a PCMH organization as it enters the PCMH program. Three years are used to account for potential year-to-year variation.

The baseline TCOC for a PCMH is defined as the risk-adjusted TCOC values of year 1, year 2, and year 3 prior to the calendar year of the current performance period. For example, for performance period 2017, the baseline is defined as CY2013, CY2014, and CY2015. CY2013 and CY2014 values are adjusted for inflation. If the PCMH does not have CY2013 and/or CY2014 values for TCOC available, then those values are replaced by CY2015 values. If the CY2015 value for TCOC is not available because membership was less than 5,000 members that year, then the PCMH does not qualify for TCOC-based shared savings.

▪ **Benchmark Total Cost of Care**

The benchmark TCOC is the figure against which a PCMH's actual TCOC will be assessed when determining performance for outcome payments. The benchmark is calculated as baseline TCOC adjusted using a common adjustment rate of 1.0% as compound annual growth rate to match the performance period. For example, the benchmark for the 2017 performance period is calculated as the 2013 to 2015

baseline, adjusted by the common adjustment rate for two years, as illustrated in Table 5. This reflects the expected cost for the PCMH.

TABLE 5 – Example of benchmark TCOC calculation

CY13-15 TCOC baseline	Benchmark rate	Growth for 1 year	2017 Benchmark TCOC
\$200	1%	\$200 X (1.01)	\$204.02

7.4 Earning Stars

In each quarterly report, PCMH organizations earn stars based on their performance across the core quality and efficiency metrics. There are five (5) quality stars and two (2) efficiency stars for a total of seven (7) stars for adult only and pediatric only PCMH organizations, and ten (10) quality stars and two (2) efficiency stars for a total of twelve (12) stars for family PCMH organizations.

- For adult practices, each adult practice quality metric that equals or outperforms the state threshold translates into one (1) quality star.
- For pediatric practices, each pediatric practice quality metric that equals or outperforms the state threshold translates into one (1) quality star.
- For family practices, each family practice quality metric that equals or outperforms the state threshold translates into one (1) quality star.
- For all practice types with low volume panel size, each efficiency metric that equals or outperforms the MCO thresholds set based on the methodology defined by the State translates into one efficiency star.

Adult and pediatric core quality and efficiency metrics are defined in Sections 7.1 and 7.2 and further detailed in Section 12 – Quality Appendix- Tables 7 and 8. State thresholds for each core metric are provided in a separate document.

Quality and efficiency metrics are calculated for all PCMH practices regardless of the number of observations in the denominator of a given metric. PCMH practices can earn stars for quality metrics that meet a minimum number of thirty (30) observations in the metric's denominator.

PCMHs must meet the minimum quality star requirement in the performance report at the end of year to qualify for outcome payments. The minimum quality star requirement

is two (2) stars for adult only and pediatric only PCMH organizations, and four (4) stars for family PCMH organizations.

7.5 Value of Stars Earned

Beginning with the 2018 performance year, redistribution of quality values may be applied under certain circumstances.

Most of the quality metrics are defined by HEDIS. HEDIS requires that an organization have at least thirty (30) observations in the denominator of any metric for it to be measured accurately. If an organization does not have at least thirty (30) observations during a calendar year for a given HEDIS metric, that organization is ineligible for that particular quality star. The potential value of each ineligible quality star will be redistributed.

The guidelines for this quality value redistribution are as follows:

- The value of each star should be rounded to the nearest tenth place.
- Quality Gate: Organizations must still meet or exceed the quality gate to qualify for an outcome payment
 - Pediatric/Adult= 2 star minimum; Family/Health Link= 4 star minimum
- Maximum redistribution: Values can only be distributed up to a certain maximum.
 - The value of up to two (2) stars, which is 20%, may be redistributed for PCMH pediatric and adult only organizations.
 - The value of up to four (4) stars, which is 20%, may be redistributed for PCMH family and Health Link organizations.
 - The value of the ineligible stars (maximum of 2 or 4) is redistributed evenly among the remaining measures regardless of the denominator of those remaining measures.
- Composite measures are defined as quality measures which consist of two (2) or more sub-metrics.
 - The value of composite measures will be redistributed when the minimum denominator is not met for all of its sub-metrics. In other words, the only way a composite measure's star value is redistributed is if the organization does not meet all of the sub-metric denominators.
 - If an organization has an eligible denominator for at least one (1) of the composite's sub-metrics, that organization will be measured against the threshold(s) and may be eligible to earn a star. In other words,

organizations will be measured on their performance, and therefore eligible for a star, for any metric for which they have a sufficient denominator in at least one sub-metric.

- Organizations must meet or exceed the threshold for every eligible sub-metric in order to earn a star.

The following charts display the value of each quality star under different circumstances.

PEDIATRIC OR ADULT ONLY PCMH

		NUMBER OF PANEL ELIGIBLE STARS				
NUMBER OF STARS EARNED		1	2	3	4	5
		16.67%	16.67%	16.67%	12.50%	10.00%
	1	0.00%	0.00%	0.00%	0.00%	0.00%
	2		33.34%	33.34%	25.00%	20.00%
	3			50.00%	37.50%	30.00%
	4				50.00%	40.00%
	5					50.00%

FAMILY PCMH

		NUMBER OF PANEL ELIGIBLE STARS									
NUMBER OF STARS EARNED		1	2	3	4	5	6	7	8	9	10
		8.33%	8.33%	8.33%	8.33%	8.33%	8.33%	7.14%	6.25%	5.56%	5.00%
	1	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	2		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	3			0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	4				33.32%	33.32%	33.32%	28.56%	25.00%	22.24%	20.00%
	5					41.65%	41.65%	35.70%	31.25%	27.80%	25.00%
	6						49.98%	42.84%	37.50%	33.36%	30.00%
	7							49.98%	43.75%	38.92%	35.00%
	8								50.00%	44.48%	40.00%
	9									50.00%	45.00%
	10										50.00%

8 RISK ADJUSTMENT

Risk adjustment is an essential analytic element of the PCMH program. Risk adjustment will be used in the TennCare PCMH program in two (2) ways:

- Risk adjustment of the activity payments PMPM; and
- Risk adjustment of total cost of care

The TennCare PCMH program utilizes the Combined Chronic Illness and Pharmacy Payment System (CDPS+Rx) version 6.1 for risk adjustment.

CDPS is a diagnosis-based risk assessment and classification system that supports health status-based capitated payments for Medicaid and Medicare populations. The CDPS model was first developed in 2000 by the University of California, San Diego (UCSD), and has since been expanded to include diagnostic and pharmacy risk assessment models. To date, approximately fifteen (15) states use CDPS to determine risk adjusted capitated payments for their Medicaid programs. The CDPS model has the option to run in either prospective or concurrent mode.

8.1 Risk adjustment for practice support payments

The CDPS prospective model is used to calculate risk score for activity payments. The prospective model was chosen because these risk scores are being calculated at the beginning of the year and will be used for the rest of the year. Based on the risk score generated for each member, the PCMH organization's average risk score is assigned to a risk band, which determines the level of the activities PMPM payment for each member in the practice. This risk adjusted activity payment amount will be recalculated each year to account for any change in the members' risk in that practice.

8.2 Risk adjustment for Total Cost of Care

The CDPS concurrent model is used to calculate risk score for total cost of care. The concurrent model was chosen because it is calibrated to reflect realized risk during a historical period. For this purpose, CDPS will be run at the end of each quarter, taking into account a claims run-out period of ninety (90) days.

9 REPORTING

PCMH providers will be sent quarterly reports detailing their efficiency and quality stars, total cost of care, and potential payments for the relevant performance period. Each MCO will send providers reports quarterly. These quarterly reports aim to provide PCMHs an interim view of the member panels that they will be held accountable for during the performance period.

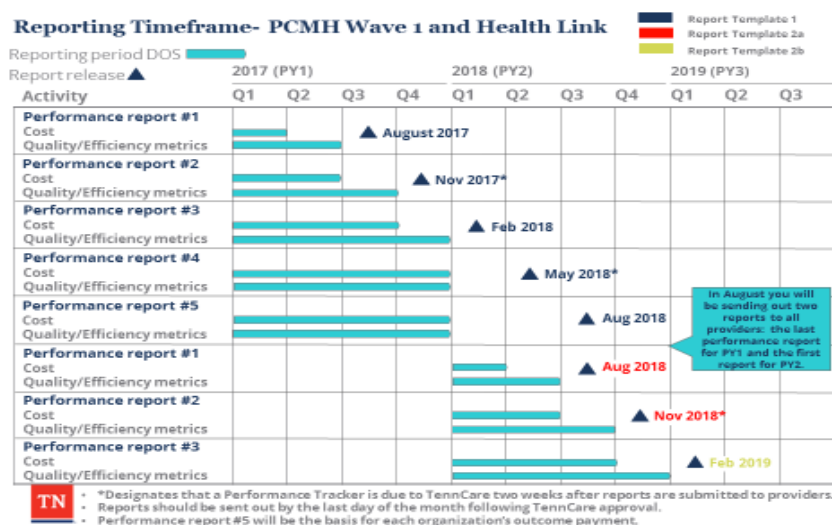
There are 2 types of quarterly provider reports:

- Preview reports; and
- Performance reports.

Initially, at program launch, PCMH providers will receive preview reports on their performance until the first claims run-out is complete, after which they will start to receive quarterly performance reports. These preview reports will give PCMHs a sense of how they were performing before the program launched. MCOs will also send providers a final annual report seven to eight months after the end of Q4 which will calculate the annual outcome payment. Only data from January 1st to December 31st of a full performance year will be included in performance evaluation.

Each quarterly performance report will provide a summary of the PCMH's total cost of care performance from the beginning of the performance period to the end of each quarter, and will incorporate ninety (90) days of claims run-out after the end of each quarter. Each performance report will also include the most recent data available for performance on quality and efficiency metrics. The final performance report will calculate the outcome payment. This final report will incorporate one hundred and eighty (180) days of claims run out after the end of the year. The following table represents the timeframes of data that will be included in each report.

TABLE 6 – Data timeframes for each quarterly report



The reports for high volume panel organizations will be different from the reports sent to low volume panel organizations because of the difference in their outcome payment calculation.

9.1 High volume panel size

High volume panel size refers to PCMHs with 5,000 or more unique attributed members in a single MCOs panel. Outcome savings percentage used to calculate outcome payments for these organizations is based on the number of quality stars and the TCOC efficiency stars.

All MCOs will use the same template to generate reports. The report will contain the following sections (A-E):

A. Quality Stars: This section summarizes the quality stars earned by the provider as of the end of the given quarter. Adult and pediatric PCMH organizations will view the 5 applicable adult/pediatric quality metrics, with each quality star contributing 10% to the outcome saving percentage. Family PCMH organizations will see all ten (10) applicable quality metrics, with each quality star contributing 5% to the outcome savings percentage.

B. Efficiency Stars: Total Cost of Care: This section outlines the provider's risk-adjusted average per member per month Total Cost of Care for the quarter. It will provide a mapping of how many efficiency stars this average total cost of care is rewarded, based on pre-determined thresholds. The potential number of efficiency stars a provider can receive is 0 through 2, with each star contributing 15% to the outcome savings percentage. This section also offers provider TCOC information by care category. The provider TCOC figures are compared to a provider average, and are provided on a non-risk adjusted basis for both total cost of care and behavioral health specific cost of care.

C. Total Cost of Care Savings Amount: The total cost of care savings amount shows how much your PCMH organization saved per member per month this year. This section shows the TCOC values for your PCMH organization necessary to determine your savings.

D. Potential for Annual Outcome Payments: This section provides information on potential (or actual, if it is the annual report) outcome payments. It lists the amount of the potential payment, and details of the calculation of that amount.

Appendix: This section contains more detail on the quality metrics performance. It includes an indication of whether the provider has met the minimum number of members for each metric and, if not, how many members are included. The section also includes a short description of each quality metric and a visual depiction of the provider performance on each metric as compared to other providers and as compared to the metric threshold for earning a star.

9.2 Low volume panel size

Low volume panel size refers to PCMHs with fewer than 5,000 unique attributed members in the panel. Outcome savings percentage used to calculate outcome payments for these practices is based on the number of quality stars and efficiency stars.

The report will contain the following sections (A-F):

A. Quality Performance: This section summarizes the quality stars earned by the provider as of the end of the given quarter. Beginning with the 2018 performance year, the redistribution of quality values may be applied under certain circumstances. Most of the quality metrics are defined by HEDIS. HEDIS requires that an organization have at least thirty (30) observations in the denominator of any metric for it to be measured accurately. If an organization does not have at least thirty (30) observations during a calendar year for a given HEDIS metric, that organization is ineligible for that particular quality star. The potential value of each ineligible quality star will be redistributed.

B. Efficiency Performance: This section summarizes the efficiency stars and efficiency improvement score, an input of the outcome payment calculation. Performance must meet or exceed the benchmark in order to earn an efficiency star. Each efficiency star earned contributes 15.00% to the efficiency performance. For the efficiency improvement score, the provider's current performance (year to date) on the two efficiency metrics is compared to a performance from the prior year to determine the PCMH improvement. The improvement percentages for each metric are averaged together to generate the total efficiency score. If the average efficiency improvement percentage results in a negative number, it will be set to 0 and if the calculation exceeds 20% it will be capped at that value.

C. Outcome Payment: This section provides information on potential (or actual, if it is the annual report) outcome payments. It lists the amount of the potential payment, and details of the calculation of that amount. The outcome payment is calculated as detailed in Section 5.3.

D. Total Cost of Care (for reporting only): This section offers provider total cost of care information by care category. The provider TCOC figures are provided on a non-risk adjusted basis for both total cost of care and behavioral health specific cost of care. This section also shows providers how they compare to other Medicaid primary care organizations throughout the state.

Appendix: This section contains more detail on the quality metrics. It includes an indication of whether the provider has met the minimum number of members for each metric and, if not, how many members are included. The section also includes a short description of each quality metric and a visual depiction of the provider performance on each metric as compared to other providers and as compared to the metric threshold for earning a star.

10 PROVIDER TRAINING

TennCare has contracted with Navigant to deliver provider training and technical assistance services to Health Link and PCMH providers across the State. Navigant will help providers make the needed investments in practice transformation across all of their sites. This in-kind training investment is intended as a co-investment with PCMH organizations and not as full coverage for the time, infrastructure, and other investments that practices will need to make.

10.1 Scope of provider training

Navigant will conduct an initial assessment of each PCMH practice that identifies current capabilities. The results of this assessment will allow the trainer to create a custom curriculum for each organization to help in meeting transformation milestones. The custom plan will be refined periodically through semi-annual assessments.

The PCMH curriculum will focus on building health care provider capabilities for effective patient population health management to reduce the rate of growth in total cost of care while improving health, quality of care, and patient experience.

This curriculum will include content in the following areas:

- a. Delivering integrated physical and behavioral health services;
- b. Team-based care and care coordination;
- c. Organization workflow redesign and management;
- d. Risk stratified and tailored care delivery;
- e. Enhanced patient access (e.g., flexible scheduling, expanded hours);
- f. Evidence-informed and shared decision making;
- g. Developing an integrated care plan;
- h. Patient and family engagement (e.g., motivational interviewing);
- i. Making meaningful use of Health Information Technology (HIT)/ Health Information Exchange (HIE);
- j. Making meaningful use of the care coordination tool (e.g., ADT feeds);
- k. Making meaningful use of provider reports;
- l. Business support; and
- m. Clinical workflow management

Providers will be encouraged to access this curriculum in various ways including:

- **On-site coaching:** on-site coaching for practice staff, e.g., one-on-one coaching sessions with small groups of organization staff including physicians, office managers, care coordinators and/or PCMH Directors.
- **Large format in-person trainings:** large-format regional conferences, trainings, or symposia three times per year in each of the Grand Regions
- **Live webinars:** live, hosted webinars with live Q&A on a quarterly basis
- **Recorded trainings:** recorded video trainings available to providers online on a self-serve basis

- **Compendium of resources:** a library of documents and resources available online

Navigant will also establish and facilitate peer-to peer **learning collaboratives** among organizations to allow PCMH providers to learn from one another's experience and to interact with behavioral health providers participating in Tennessee Health Link. To enable learning and adoption at the organization level, Navigant will create mechanisms for providers to share best practices, to collaborate on common problems, and to adopt and refine evidence-informed protocols.

MCOs may choose to supplement this in-kind training with new or existing programs geared toward PCMH training. Navigant will coordinate support with MCOs to minimize duplication and maximize efficiency for the MCO, vendor, and providers alike. For example, MCOs will be encouraged to join on-site coaching sessions where they will be able to share their performance data and advice directly with PCMH organizations.

10.2 Timeline of provider training

Navigant began scheduling initial assessments for Wave 2 PCMHs in December 2017. Onsite coaching sessions will begin once the initial assessments are complete.

10.3 Duration of provider training

Navigant will develop individualized curricula for both PCMH and Tennessee Health Link that cover the first two (2) years of an organization's transformation.

Payments to Navigant on behalf of a participating organization will continue for two (2) years. Over time (i.e., once federal funding is no longer available to support the training and technical assistance vendor), the MCOs will take over Navigant's training role.

11 CARE COORDINATION TOOL (CCT)

A shared, multi-payer Care Coordination Tool (CCT) will allow PCMH organizations to better coordinate care for their attributed members. The tool is designed to offer useful, up-to-date information to PCMH organizations.

The State of Tennessee is contracted with Altruista Health for development of the Care Coordination Tool, based on Altruista's Guiding Care platform. Guiding Care is a cloud based tool accessible online. Practices will not have to install any special programs.

Information in the tool will be populated by claims data from the State; MCOs; and Admission, Discharge, and Transfer data received from participating hospitals.

Using the CCT is a provider activity requirement for PCMH; however, we expect PCMH organizations will each use the tool differently after assessing its capabilities and integrating its usage into their current work flows.

11.1 Care Coordination Tool (CCT) Functionalities

The CCT has several functionalities including:

- Displays providers' attributed member panels;
- Calculates members' risk scores and stratifies providers' panels for more focused outreach;
- Generates, displays, and records closure of gaps-in-care; and
- Displays hospital and ED admission, discharges, and transfers (ADTs).

The tool enables providers to see real-time information about members in need of follow-ups, which will allow providers to manually close gaps in care. At this time, those manual gaps in care closures will not contribute to the quality performance reported from the MCOs each quarter unless a corresponding claim is received to verify the gap has been closed.

11.2 CCT User Expectations

Although daily use of the CCT is not strictly required, it is expected that PCMH organizations will designate staff, ideally care coordinators, to use the tool daily. Any staff using the CCT is expected to abide by patient privacy and confidentiality laws and regulations.

11.3 TennCare Provider Registration Portal (PDMS)

In order for the provider information to display accurately in the CCT, each PCMH must ensure that their registration is up to date in the PDMS.

All individual providers must be **entered and added** into the individual registration portal (PDMS) to be affiliated within the organization's registration. Once an individual provider is registered, they should appear in the CCT for that organization. Each PCMH organization will be responsible for updating its list of providers in the PDMS; the CCT will reflect any changes made in the PDMS within one week.

To register and add individual providers to the PDMS, both of the following steps must be completed:

1. Registration for ALL Individual Providers:
 - a. Navigate to: <https://pdms.tenncare.tn.gov/ProviderPersonRegistration/Process/Register.aspx> and complete all entries.
 - b. Complete the CAQH profile for the individual provider at: <https://proview.caqh.org/Login>. Note: Please make sure to authorize TennCare access to the information to enable TennCare to receive the file information from CAQH.
2. Adding the Individual Providers to the Entity/Group:
 - a. Navigate to <https://pdms.tenncare.tn.gov/Account/Login.aspx> and log in.
 - b. Select **Add Affiliations**
 - c. Select **Individual Providers**
 - d. Select the **green plus sign**
 - e. Add the individual provider information (name, individual NPI, and start date).

11.4 How to Access the CCT

Altruista will be responsible for setting up all users with logins and passwords. If you want access to the CCT and haven't received a user name and password yet, contact your practice's point of contact for the CCT. If you do not know who that is, email hcfa.spigcct@tn.gov.

Each user will be required to sign security forms electronically to ensure that health information is protected.

Once login credentials have been created and sent to new users via email from Altruista, the Care Coordination Tool landing page can be accessed at: <https://tn.guidingcare.com/TennCare/Account/Login?ReturnUrl=%2fTennCare%2f>.

If you have **any issues** with **or questions** regarding the Care Coordination Tool, contact the Altruista Help Desk at 855-596-2491 or support@altruistahealth.com.

11.5 CCT Training Sessions and Materials

The State and Altruista will host online trainings and develop easy to understand self-guided user materials so that providers are comfortable with all functionalities available in the CCT. It is recommended that new users review training materials prior to using the tool. To join an upcoming training session, email hcfa.spigcct@tn.gov. Training sessions will be held a few times per year; specific details about the training session dates will be provided via email.

Self-guided training materials can be found on the State's website: <https://www.tn.gov/tenncare/health-care-innovation/primary-care-transformation/care-coordination-tool.html>. Updates to the training materials online will be made on an ongoing basis.

11.6 Data in the Care Coordination Tool (CCT)

Member attribution data in the CCT is derived directly from the Managed Care Organizations and is updated once per week. The primary source of data within the CCT is paid claims which determine patient diagnoses, pharmacy information, risk scores, and gaps in care for members. Please note that information regarding substance use or treatment is not available within the CCT due to federal regulations.

In the future, more member data will be available within the CCT. The State is currently collaborating with the Department of Health in order to determine the feasibility of including immunization data from the Tennessee Immunization Information System (TennIIS) in the CCT. Additionally, the State is working with the Tennessee Hospital Association to include state-wide hospital coverage. Furthermore, both primary care and behavioral health providers will be able to see when their patients have filled prescriptions in more real-time.

12 QUALITY APPENDIX

TennCare has selected a group of core quality metrics for the PCMH program. TennCare recognizes that this is not the complete set of measures required for a member to be considered compliant across all HEDIS measures. TennCare encourages PCMHs to continue to work closely with the MCOs to identify and close those care opportunities.

The descriptions for HEDIS measures below are based on HEDIS 2018 specifications. Practices will always be measured on the most recent HEDIS specifications available.

TABLE 7 – Core quality metrics

Category	Core metric	Source	Description	Threshold
Quality metrics for adult practices	Adult BMI assessment	HEDIS (ABA)	% of patients, ages 18-74 years, with an OP visit whose BMI was documented during the measurement year or the year prior	≥60%
	Antidepressant medication management (adults only)		% of 18 and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant regime;	
	– Acute phase	HEDIS (AMM)	% who remained on antidepressant medication for at least 84 days (12 weeks)	≥55%
	– Continuation phase	HEDIS (AMM)	% who remained on antidepressant medication for at	≥40%

Category	Core metric	Source	Description	Threshold
			least 180 days (6 months)	
	Comprehensive diabetes care composite number 1		% of patients 18 to 75 years of age with type 1 or type 2 diabetes;	
	– Comprehensive Diabetes Care: Eye exam (retinal) performed	HEDIS (CDC)	% who had an eye exam (retinal) performed	≥40%
	– Comprehensive Diabetes Care: BP control (<140/90 mm Hg)	HEDIS (CDC)	% whose most recent blood pressure reading is less than 140/90 mm Hg (controlled)	≥50%
	– Comprehensive diabetes care: Medical attention for nephropathy	HEDIS (CDC)	% who received medical attention for nephropathy	≥85%
	Comprehensive diabetes care composite number 2		% of patients 18 to 75 years of age with type 1 or type 2 diabetes who	
	– Comprehensive diabetes care: Hemoglobin A1c (HbA1c) testing	HEDIS (CDC)	% with HbA1c test performed in the measurement year	≥85%
	– Comprehensive diabetes care: HbA1c poor control (>9.0%)	HEDIS (CDC)	% with most recent HbA1c level during the measurement	≤50%

Category	Core metric	Source	Description	Threshold
			year greater than 9.0%	
	EPSDT: Adolescent well-care visits age 12-21	HEDIS (AWC)	Percentage of enrolled patients 12-21 years of age who had at least one comprehensive well-care visit with a PCP or OB/GYN during the measurement year	≥45%
Quality metrics for pediatric practices	EPSDT (composite for older kids)			
	– EPSDT: Well-child visits ages 7-11 years	TennCare	Percentage of patients 7-11 years of age who had one or more well-child visits with a PCP during the measurement year	≥55%
	– EPSDT: Adolescent well-care visits age 12-21	HEDIS (AWC)	Percentage of enrolled patients 12-21 years of age who had at least one comprehensive well-care visit with a PCP or OB/GYN during the measurement year	≥45%

Category	Core metric	Source	Description	Threshold
	EPSDT (composite for younger kids)			
	<ul style="list-style-type: none"> – EPSDT: Well-child visits first 15 months – 6 or more visits 	HEDIS (W15)	Percentage of patients who turned 15 months of age during the measurement year and who had 6+ well-child visits with a PCP during their first 15 months of life	≥45%
	<ul style="list-style-type: none"> – EPSDT: Well-child visits at 18, 24, & 30 months 	TennCare	<p>The percentage of members who turned 35 months old during the measurement timeframe who had at least one well-child visit within each of the following intervals:</p> <ul style="list-style-type: none"> • 2 weeks before 18 month up to 2 weeks before 24 months • 2 weeks before 24 month up to 2 weeks before 30 months • 2 weeks before 30 month up to 35 months 	≥34%

Category	Core metric	Source	Description	Threshold
			<ul style="list-style-type: none"> • Total: at least one visit during each of the three intervals above 	
	– EPSDT: Well-child visits ages 3-6 years	HEDIS (W34)	Percentage of patients 3-6 years of age who had one or more well-child visits with a PCP during the measurement year	≥65%
	Asthma medication management	HEDIS (MMA)	% of members during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. The rate included in this measure is the % of members in this age group who remained on an asthma controller medication for at least 75% of their treatment – Total rate	≥30%

Category	Core metric	Source	Description	Threshold
	Immunization composite metric (children and adolescents only)			
	– Childhood immunizations – Combination 3	HEDIS (CIS)	% children 2 years of age who had 4 DTap, 3 polio, 1 MMR, 3 HiB, 3 HepB, 1 VZV, and 4 PCV by their second birthday	≥45%
	– Immunizations for adolescents – Total rate- Combination 2	HEDIS (IMA)	The % of adolescents 13 years of age who had one dose of meningococcal vaccine, one Tdap and have completed the HPV vaccine series by their 13th birthday	≥16%
	Weight assessment and nutritional counseling for children/adolescents	HEDIS (WCC)	Weight assessment and counseling for children/adolescents ages 3-17, defined as:	
	– BMI percentile	HEDIS (WCC)	BMI percentile: % of members who had an outpatient visit with a PCP or OB/GYN and whose body mass	≥30%

Category	Core metric	Source	Description	Threshold
			index (BMI) was documented during the measurement year or the year prior to the measurement year.	
	– Counseling for nutrition	HEDIS (WCC)	Counseling for nutrition: % of member who had an outpatient visit with a PCP or OB/GYN who had evidence of counseling for nutrition during the measurement year	≥30%
Quality metrics for family practices	EPSDT (composite for older kids)			
	– EPSDT: Well-child visits ages 7-11 years	TennCare	Percentage of patients 7-11 years of age who had one or more well-child visits with a PCP during the measurement year	≥55%
	– EPSDT: Adolescent well-care visits age 12-21	HEDIS (AWC)	Percentage of enrolled patients 12-21 years of age who had at least one comprehensive well-care visit	≥45%

Category	Core metric	Source	Description	Threshold
			with a PCP or OB/GYN during the measurement year	
	EPSDT (Composite for younger kids)			
	– EPSDT: Well-child visits first 15 months – 6 or more visits	HEDIS (W15)	Percentage of patients who turned 15 months of age during the measurement year and who had 6+ well-child visits with a PCP during their first 15 months of life	≥45%
	– EPSDT: Well-child visits at 18, 24, & 30 months	TennCare	<p>The percentage of members who turned 35 months old during the measurement timeframe who had at least one well-child visit within each of the following intervals:</p> <ul style="list-style-type: none"> • 2 weeks before 18 month up to 2 weeks before 24 months • 2 weeks before 24 month up to 2 	≥34%

Category	Core metric	Source	Description	Threshold
			<p>weeks before 30 months</p> <ul style="list-style-type: none"> 2 weeks before 30 month up to 35 months Total: at least one visit during each of the three intervals above 	
	EPSDT: Well-child visits ages 3-6 years	HEDIS (W34)	Percentage of patients 3-6 years of age who had one or more well-child visits with a PCP during the measurement year	≥65%
	Immunization composite metric (children and adolescents only)			
	<ul style="list-style-type: none"> Childhood immunizations – Combination 3 	HEDIS (CIS)	% children 2 years of age who had 4 DTaP), 3 polio, 1 MMR, 3 HiB, 3 HepB, 1 VZV, and 4 PCV by their second birthday	≥45%
	<ul style="list-style-type: none"> Immunizations for adolescents – Total rate-Combination 2 	HEDIS (IMA)	The % of adolescents 13 years of age who had one	≥16%

Category	Core metric	Source	Description	Threshold
			dose of meningococcal vaccine, one Tdap and have completed the HPV vaccine series by their 13th birthday	
	Asthma medication management	HEDIS (MMA)	The % of members during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. The rate included in this measure is the % of members in this age group who remained on an asthma controller medication for at least 75% of their treatment – Total rate	≥30%
	Adult BMI assessment	HEDIS (ABA)	% of patients, ages 18-74 years, with an OP visit whose BMI was documented during the measurement	≥60%

Category	Core metric	Source	Description	Threshold
			year or the year prior	
	Weight assessment and counseling for nutrition for children/adolescents	HEDIS (WCC)	Weight assessment and counseling for children/adolescents ages 3-17, defined as:	
	– BMI percentile	HEDIS (WCC)	BMI percentile: % of members who had an outpatient visit with a PCP or OB/GYN and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.	≥30%
	– Counseling for nutrition	HEDIS (WCC)	Counseling for nutrition: % of members who had an outpatient visit with a PCP or OB/GYN who had evidence of counseling for nutrition during the measurement year	≥30%
	Antidepressant medication	HEDIS (AMM)	% of 18 and older who were treated with	

Category	Core metric	Source	Description	Threshold
	management (adults only)¹		antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant regime; report	
	– Acute phase	HEDIS (AMM)	% who remained on antidepressant medication for at least 84 days (12 weeks)	≥55%
	– Continuation phase	HEDIS (AMM)	% who remained on antidepressant medication for at least 180 days (6 mo.)	≥40%
	Comprehensive diabetes care composite number 1		% of patients 18 to 75 years of age with type 1 or type 2 diabetes who	
	Comprehensive Diabetes Care: Eye exam (retinal) performed	HEDIS (CDC)	% who had an eye exam (retinal) performed	≥40%
	Comprehensive Diabetes Care: BP control (<140/90 mm Hg)	HEDIS (CDC)	% whose most recent blood pressure reading is less than 140/90 mm Hg (controlled)	≥50%
	Comprehensive diabetes care: Medical	HEDIS (CDC)	% who received medical attention for nephropathy	≥85%

Category	Core metric	Source	Description	Threshold
	attention for nephropathy			
	Comprehensive diabetes care composite number 2		% of patients 18 to 75 years of age with type 1 or type 2 diabetes who	
	Comprehensive diabetes care: Hemoglobin A1c (HbA1c) testing	HEDIS (CDC)	% with HbA1c test performed in the measurement year	≥85%
	Comprehensive diabetes care: HbA1c poor control (>9.0%)	HEDIS (CDC)	% with most recent HbA1c level during the measurement year greater than 9.0%	≤50%

¹ Designates a unique HEDIS reporting timeframe that is not based on information with a date of service during a standard calendar year.

TABLE 8 – Core efficiency metrics

Each MCO will set thresholds for core efficiency metrics. The State has provided each MCO guidance on setting these thresholds. This guidance can be found on the State's PCMH website.

Category	Core metric	Source	Description
Efficiency metrics	Ambulatory care - ED visits per 1,000 member months	HEDIS (AMB)	Number of ED visits per 1,000 member months
	Inpatient discharges per 1,000 member months – Total inpatient	HEDIS (IPU)	Number of acute inpatient discharges per 1,000 member months

TABLE 9- Total cost of care categories

Each PCMH organization will receive a breakdown of their TCOC by category in each quarterly report. Only high volume PCMHs will generate outcome payments based on these values.

■ Category	■ Description
■ Inpatient facility	■ All services provided during an inpatient facility stay including room and board, recovery room, operating room, and other services.
■ Emergency department or observation	■ All services delivered in an Emergency Department or Observation Room setting including facility and professional services.
■ Outpatient facility	■ All services delivered by a facility during an outpatient surgical encounter, including operating and recovery room and other services.
■ Inpatient professional	■ Services delivered by a professional provider during an inpatient hospital stay, including patient visits and consultations, surgery, and diagnostic tests.
■ Outpatient laboratory	■ All laboratory services in an inpatient, outpatient, or professional setting.
■ Outpatient radiology	■ All radiology services such as MRI, X-Ray, CT and PET scan performed in an inpatient, outpatient, or professional setting.

■ Category	■ Description
■ Outpatient professional	■ Uncategorized professional claims such as evaluation and management, health screenings, and specialists visits.
■ Pharmacy	■ Any pharmacy claims billed under the pharmacy or medical benefit with a valid National Drug Code.
■ Other	■ PCMH support payments, DME, transportation, Home health, and any remaining uncategorized claims.

For purposes of the PCMH program, there are six (6) categories of spending excluded from the TCOC calculation:

- Dental
- Transportation
- NICU and nursery
- Any spending during the first month of life
- Mobile Crisis Capitation payments
- Medication therapy management (MTM) payments for CY2018